l '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/04/2011
	PROVIDER OR SUPPLIEI	TH CARE CENTER	3301 N	ADDRESS, CITY, STATE, ZIP CODE I CALUMET AVE RAISO, IN46383	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
K0000	and State Lice conducted by Department of with 42 CFR 4 Survey Date: Facility Number Provider Number AIM Number Surveyor: Rice Safety Code Seafety Code (Seafety	os/04/11 oer: 000176 ber: 155277 100288940 chard D. Schade, Life specialist afety Code survey, ines Health Care und not in compliance ments for Participation Medicaid, 42 CFR 0(a), Life Safety from 000 edition of the Protection NFPA) 101, Life LSC), Chapter 19, th Care Occupancies	K0000	This Plan of Correction constitutes the written allegated of compliance for the deficiencited. However, submission this Plan of Correction is not admission that a deficiency or that one was cited correct. This Plan of Correction is submitted to meet requirem established by state and feet law. Whispering Pines desirn this Plan of Correction to be considered the facility's Alle of Compliance. Compliance effective on June 3, 2011.	encies n of t an exists ettly. ents deral ees egation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

VO7T21

Facility ID:

000176

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155277		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE S COMPL 05/04/20	ETED	
	PROVIDER OR SUPPLIER		p. wind	STREET A	DDRESS, CITY, STATE, ZIP CODE CALUMET AVE RAISO, IN46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	story buildings be of Type II (was fully sprin has a fire alarm detection in the sleeping rooms the corridors. capacity of 150 114 at the time Quality Review by I Safety Code Special 05/06/11. The facility was compliance with aforementioners.						
K0054 SS=E	activating door hol approved, maintain accordance with the	9.6.1.3	 K0	054	It is the policy of this facility t	0	06/03/2011

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
1111212111	or condition.	155277	- 1	LDING		05/04/2011
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER	2		1	CALUMET AVE	
		TH CARE CENTER		<u> </u>	RAISO, IN46383	
(X4) ID PREFIX	·			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	interview, the	facility failed to			ensure smoke detectors are	
	ensure 1 of 1 s	smoke detectors in the			approved, maintained, inspe and tested in accordance wi	l l
	facility's Pines	South day room			manufacturer's specification	s. I.
	were installed	where air flow would			Specific Corrective Actions Pines South Day room smok	
	not adversely	affect its operation.			detector was relocated so it	l l
	LSC 9.6.1.3 sa	ays the provisions of			within two feet of the air sup duct to ensure air flow would	· ·
	9.6 cover the b	pasic functions of a			adversely affect the smoke	11100
	complete fire	alarm system.			detector's operation. II.	
	Section 9.6.1.4	4 requires fire alarm			Identification and correction others: All smoke detectors	
	systems comply with NFPA 72, National Fire Alarm Code. NFPA				inspected to ensure they we	re not
					within two feet of an air supp duct. III. Systemic Changes	
	72, 2-3.5.1 rec	quires in spaces			NFPA 72, 2-3.5.1 requireme	
	served by air l	nandling systems,			will be reviewed with mainte	
	detectors shall	not be located where			staff before June 3, 2011. IV Monitoring: Rounds will be	l l
	air flow preve	nts operation of the			monthly, for at least six mon	ths,
	detectors. Thi	s deficient practice			to check if any air supply due are within two feet of any sm	
	could effect re	esidents in and near			detector.	
	the day room	smoke detector,				
	including staff	f and visitors.				
	Findings inclu	ide:				
	Based on obse	ervation with the				
	maintenance s	upervisor on				
	05/04/11 at 3:2	25 p.m., the smoke				
	detectors in th	e Pines South day				
	room was loca	ated within two feet of				
	an air supply o	duct. This was				
	acknowledged	by the maintenance				
						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155277		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/04/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 N CALUMET AVE VALPARAISO, IN46383				
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR Supervisor at the observation.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) he time of the	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
K0143 SS=E	wherein patients a treated by a separ 1-hour fire-resistive (b) in an area that sprinklered, and his flooring; and (c) in an area post transferring is occur the immediate are accordance with N Compressed Gas. Based on obseinterview, the ensure 3 of 3 l areas were proindicating oxy occurring. The could affect revisitors in and	any portion of a facility re housed, examined, or ation of a fire barrier of e construction; is mechanically ventilated, as ceramic or concrete ed with signs indicating that urring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 rvation and facility failed to iquid oxygen storage vided with signage gen transferring is is deficient practice sidents, staff and near the oxygen insfilling rooms.	K014	13	It is the policy of this facility to ensure we are following NFP is and the Compressed Gas Association's standards. I. Specific Corrective Actions: Temporary signage is posted and permanent signs ordered to indicate where oxitransferring is occurring. II. Identification and correction others: There are only three oxygen storage rooms, all the rooms were posted with requisignage. III. Systemic Changes: The NFPA 99 and	A 99' was ygen n of	06/03/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VO7T21

Facility ID:

000176

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/04/2011	
	PROVIDER OR SUPPLIER	TH CARE CENTER	STREET A 3301 N	ADDRESS, CITY, STATE, ZIP CODE CALUMET AVE RAISO, IN46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	maintenance s tour of the fact p.m. and 3:55 facility's oxyge transfilling roo provided with transferring of occurring. Ba the time of obs maintenance s acknowledged oxygen does o storage and tra no sign indicat of oxygen was facility's oxygen	a sign indicating Coxygen was sed on interview at servation, the		Compressed Gas Association requirements will be reviewed with maintenance staff befor June 3, 2011. IV. Monitoring The maintenance staff will comonthly, for at least six mon that the signs are in place.	ed e g <u>:</u> heck
K0144 SS=F			K0144	It is the policy of this facility	to 06/03/2011
		facility failed to	K0144	ensure generators are inspe weekly and exercised under for 30 minutes per month in	cted

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION 01			(X3) DATE SURVEY COMPLETED	
		155277	1			05/04/2	
AND PLAN	PROVIDER OR SUPPLIER RING PINES HEAL SUMMARY S (EACH DEFICIEN REGULATORY OR ensure 2 of 3 of were equipped stops. LSC 7. emergency ge power to emer	TH CARE CENTER STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Emergency generators I with remote manual		ILDING NG STREET A 3301 N	DISTRUCTION 01 OT ADDRESS, CITY, STATE, ZIP CODE CALUMET AVE RAISO, IN46383 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) accordance with NFPA 99. I. Specific Corrective Actions generator company was contacted to determine if the generators without remote manual stops were Level II installations and of a horsept rating that required a remote off device. One of the two generators is a 42.5 horsepto	COMPL 05/04/2 05/04/2 The two ower shut	ETED
	NFPA 110, Sta and Standby F 110, 1999 edit Level II instal remote manua type similar to located elsewl where the prir outside the bu Standard for the Use of Station Engines and C Edition, at 8-2 of 100 horsepo provision for the remote location practice could	Power Systems. NFPA and and are shall have a lations shall have a lations shall have a lation shall have a lation shall have a lation shall have a lation of a lation and have shall are combustion as Turbines, 1998 and lation and from a lation. This deficient lation and from a lation and			generators is a 42.5 horsepo and does not require a remote shut off, the second is a 228 horsepower and a remote sh will be installed prior to June 2011. II. Identification and correction of others: There only three generators on the property, one already has a remote shut off device, one cont require a remote shut off the last will have one installe Systemic Changes: The NFF 110, Standard for Emergency Standby Power Systems will reviewed with maintenance shefore June 3, 2011. IV. Monitoring: Rounds will be comonthly, for at least six mont to ensure the remote shut off in place.	te ut off 3, are does , and d.III. PA y and be staff done ths,	

PRINTED: 05/18/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155277		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/04/2011	
	PROVIDER OR SUPPLIER		3301 N	ADDRESS, CITY, STATE, ZIP CODE CALUMET AVE RAISO, IN46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance r 2:25 p.m. with supervisor, the documentation indicated the h the generator of Based on inter- maintenance s record review, shut off devices sets one and the maintenance s	a available which corsepower ratings of engines provided. view with the upervisor during he stated no remote e existed for generator			
K0154 SS=F	is out of service fo 24-hour period, the jurisdiction is notifi evacuated or an a is provided for all I	ed, and the building is pproved fire watch system parties left unprotected by the sprinkler system has ervice. 9.7.6.1	K0154	It is the policy of this facility t provide a complete written p	

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Event ID: VO7T21

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155277		A. BUII	LDING	NSTRUCTION 01	(X3) DATE S COMPL 05/04/20	ETED	
AND PLAN	AME OF PROVIDER OR SUPPLIER WHISPERING PINES HEALTH CARE CENTER ### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 150 of 150 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, 9.7.6.2 requires sprinkler impairment procedures comply with		LDING G STREET A 3301 N	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) regarding procedure to be followed in the event the automatic sprinkler system h be placed out of service for 4 hours or more in a 24 hour period. I. Specific Corrective Actions: The maintenance of the Fire Watch Policy was older policy, the policy was updated in January of 2010 t include the required phone numbers and that the staff m be designated and trained. The maintenance book was updated with the most current policy. Identification and correction.	as to ppy an oust The ted I. n of	ETED	
	NFPA 25, Star Testing and M Based Fire Pro NFPA 25, 11-5 fire department sprinkler imparequires the incompany, built and other auth jurisdiction also This deficient all occupants including residuistors.	aintenance of Water of tection Systems. S(d) requires the local at to be notified of a sirment and 11-5(e) surance carrier, alarm ding owner/manager orities having so to be notified. practice could affect in the facility dents, staff and			others: All policy books were checked to make sure they contained the most recent ve of our Fire Watch Policy.III. Systemic Changes: The curr version of our Fire Watch Powill be reviewed with the management team before Ju 2011. IV. Monitoring: The maintenance supervisor or designee will check monthly ensure their Fire Watch Police the same as the one in Administration and on each for the same as the one and the same as the same as the one and the same as the one and the same as th	ersion ent licy ane 3, to cy is	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155277		(X2) MULTIPLE CC A. BUILDING B. WING	01	COMP	(X3) DATE SURVEY COMPLETED 05/04/2011	
	PROVIDER OR SUPPLIER	TH CARE CENTER	STREET A 3301 N	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE RAISO, IN46383	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	maintenance s 05/04/11 at 2:1 watch procedu service automa was incomplet lacked the tele the Indiana Sta Health (317-2:1 local fire depa include staff m and trained to rounds. The in maintenance s of the record r	15 p.m., the fire are for an out of atic sprinkler system are. The procedure sphone numbers for ate Department of 33-5359) and the artment and it did not must be designated perform fire watch anterview with the appropriate the time eview indicated no a procedure was				
K0155 SS=F	service for more the period, the authorinotified, and the bapproved fire water left unprotected by	fire alarm system is out of nan 4 hours in a 24-hour ity having jurisdiction is uilding is evacuated or anoth is provided for all parties the shutdown until the fire been returned to service.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155277		(X2) MI A. BUII B. WIN	LDING	01	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER	TH CARE CENTER	•	3301 N	ADDRESS, CITY, STATE, ZIP CODE CALUMET AVE RAISO, IN46383		
	Based on reco interview, the provide a com containing profollowed in the system has to service for four 24 hour period 150 residents, LSC, Section 19.7.1.1 require occupancy to available to all personnel a ple of all persons, periodically be informed with duties under the provisions of 19.7.2.3 shall requires all fire	TH CARE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) rd review and facility failed to plete written policy ocedures to be e event the fire alarm be placed out of in hours or more in a l to protect 150 of in accordance with 9.6.1.8. LSC, res every health care have in effect and l supervisory an for the protection All employees shall e instructed and kept respect to their		3301 N	CALUMET AVE	to olicy has to 4 e oppy han to hust The ated II. n of e ersion rent olicy has 3, to	(X5) COMPLETION DATE 06/03/2011
	department an 19.7.2.3 requir personnel to b of a code phra	e instructed in the use			Administration and on each	ноог.	
	malfunction of	f the building fire					

 '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ	2) MULTIPLE CO	NSTRUCTION 01		(X3) DATE : COMPL	
THE LEAN	C. COMMECTION	155277		BUILDING	<u> </u>		05/04/2	
			<u>IR</u> .	WING STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				CALUMET AVE	•		
WHISPE		TH CARE CENTER		VALPAF	RAISO, IN46383			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCEI	D TO THE APPROPRIAT CIENCY)	E	COMPLETION DATE
		This deficient						
		affect all residents,						
	staff and visito							
	Findings inclu	de:						
	2							
	Based on revie	ew of the facility's						
		cedure book with the						
	maintenance s	upervisor on						
	05/04/11 at 2:1	15 p.m., the fire						
	watch procedu	re for an out of						
	service automa	atic alarm system was						
	not complete.	The procedure						
	_	uired telephone						
	numbers for th	e Indiana State						
	Department of	Health						
	(317-233-5359	and the local fire						
	department an	d it did not include						
	staff must be d	lesignated and trained						
	to perform fire	e watch rounds. The						
	maintenance s	upervisor stated at						
	the time of rec	ord review, he had no						
	other policy or	procedure available						
	to review.							
	3.1-19(b)							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	V07	T21 Facility I	D: 000176	If continuation sl	neet Pa	ge 11 of 11